U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 08Aug2001

CASE No.: 2000-BLA-00905

In the Matter of:

CHARLES HASHIN
Claimant

v.

READING ANTHRACITE COMPANY
Employer

and

LACKAWANNA CASUALTY COMPANY
Carrier

and

DIRECTOR, OFFICE of WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

Appearances:

Carolyn Marconis, Esq.
For the Claimant

A. Judd Woytek, Esq.
For the Employer

Before: Ainsworth H. Brown
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS
ON MODIFICATION

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq (the Act). The Act provides benefits to persons totally disabled due to pneumoconiosis and to certain survivors of persons who had pneumoconiosis and were totally disabled at the time of their death or whose death was caused by pneumoconiosis. Pneumoconiosis is a chronic dust disease of the lungs, including respiratory and pulmonary impairments arising out of coal mine employment, and is commonly referred to as black lung.

On June 16, 2000, the Director, Office of Workers' Compensation Programs, referred this case to the Office of Administrative Law Judges for a formal hearing. DX-183.[1] A hearing was held before me in Reading, Pennsylvania on February 21, 2001, at which time all parties were given a full opportunity to present evidence and argument as provided in the Act and the Regulations issued thereunder, found at Title 20, Code of Federal Regulations.[2] Claimant's Exhibits 1-9, Director's Exhibits 1-183, and Employer's Exhibits 1-5 were entered into the record at the formal hearing, *see* TR-3-5, and, with the receipt of Claimant's final exhibit, CX-10, the record was closed on March 19, 2001.

ISSUES

The parties have stipulated that Claimant be credited with 35 years of qualifying coal mine employment. *See* DXs-52, 122, 183. The following issues remain in this case, however:

(1) Whether Claimant has established a change in conditions and is entitled to modification of the duplicate claim; and, if so,

(2) whether Claimant has established a material change in conditions in his duplicate claim; and, if reached,

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[1] The following references will be used herein: "TR" for hearing transcript, "CX" for Claimant's Exhibit, "DX" for Director's Exhibit and "EX" for Employer's Exhibit.

[2] On December 20, 2000, the Secretary of Labor adopted amendments to the Black Lung Regulations. Although the Amendments took effect on January 19, 2001, their application has been challenged, and, on February 9, 2001, the United States District Court for the District of Columbia enjoined the application of the Amendments "except where the adjudicator, after briefing by the parties to the pending claim, determines that the regulations at issue in the instant lawsuit will not affect the outcome of this case." *National Mining Ass'n. v. Chao*, No. 1:00CV03086 (EGS), slip op. 3 (D.D.C. Feb. 9, 2001). By Order, dated February 13, 2001, the undersigned directed the parties to demonstrate how the Amendments would affect the outcome of this claim. Claimant and the employer, by letter dated February 14, 2001, indicated that they have stipulated that the application of the regulations as amended will not affect the outcome of this case. The Director on March 19th submitted a memorandum taking the same position. Having reviewed the administrative record as well as the responses to the February 13 Order, I conclude that the application of the Amendments would not affect the outcome of this claim.

(3) whether Claimant is entitled to benefits based on the record as a whole by establishing that he suffers from pneumoconiosis arising out of his coal mine employment and is totally disabled as a result.

For the reasons stated herein, I find that Claimant has failed to establish that he is entitled to modification of the duplicate claim, and that as a result this duplicate claim must therefore be denied because a material change has not been demonstrated. Claimant is therefore not entitled to benefits under the Act.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background and Procedural History

Charles Hashin, Claimant, was born on January 1, 1927. DX-1. He was married to Mary R. Albertini on July 23, 1960, and they remain together. DX-19-11; TR-10. She is Claimant's dependent for purposes of possible augmentation under the Act. Claimant left the mines in 1983, having suffered a back injury. He underwent coronary bypass surgery in 1990.

Claimant initially filed for benefits under the Act on April 28, 1987. DX-19-1. That claim was finally denied on September 1, 1988, after a formal hearing before Administrative Law Judge Thomas W. Murrett. DX-19. This initial filing was not further pursued.

Claimant filed the instant claim on April 24, 1990. DX-1. This claim was administratively denied by the Office of Workers' Compensation Programs (OWCP) on June 11, 1990. DX-12. The clam was referred to the Office of Administrative Law Judges (OALJ) on September 13, 1990 for formal adjudication. DX-20. A formal hearing was conducted on June 12, 1991, before Administrative Law Judge Paul H. Teitler. DX-35. On November 6, 1991, Judge Teitler issued a Decision and Order denying benefits. DX-36.

Claimant filed a Petition for Modification of this denial on October 5, 1992. DX-37. On April 23, 1993, the district director issued a Memorandum of Informal Conference denying the claim. DX-52. On July 19, 1993, the Director referred this matter to the OALJs for a formal hearing. DX-59. That proceeding was held on April 21, 1994 before Administrative Law Judge Robert D. Kaplan. DX-99. In a Decision and Order issued on November 15, 1994, Judge Kaplan denied benefits, finding that Claimant failed to prove the existence of pneumoconiosis, and thus did not establish either a material change in conditions, 20 C.F.R. § 725.309(d), or a change in condition on modification. 20 C.F.R. § 725.310. DX-100. Claimant appealed this denial to the Benefits Review Board, which affirmed Judge Kaplan's Decision

and Order on August 24, 1995.[3] DX-108; *Hashin v. Reading Anthracite Co.*, BRB No. 95-0708 BLA (Aug. 24, 1995)(unpub.).

On November 16, 1995, Claimant lodged a second Petition for Modification, and proffered additional evidence. DX-109. This Petition was denied by the district director, who issued a Proposed Decision and Order Denying Request for Modification on August 29, 1996. DX-117. This denial became final, with the issuance on October 18, 1996 of a Final Memorandum of Informal Conference which conveyed the district director's recommendation that the claim be denied. DX-122. On January 23, 1997, this matter was again referred to the OALJs for formal adjudication. DX-126. Claimant, by counsel's letter dated March 17, 1997, waived a formal hearing,[4] and on November 17, 1997, Administrative Law Judge Kaplan issued a Decision and Order Denying Benefits, finding that Claimant had failed to establish pneumoconiosis. DX-148.

Claimant appealed this denial to the Benefits review Board. On December 8, 1998, the Board again affirmed the denial of benefits. *Hashin v. Reading Anthracite Co.*, BRB No. 98-0401 BLA (Dec. 8, 1998)(unpub.). By Order dated July 15, 1999, the Board denied Claimant's *pro se* Motion for Reconsideration. DX-161.

On November 8, 1999, Claimant again filed a Petition for Modification, the third such request, alleging both a mistake in determination of fact and change in his condition. DX-162; *see generally Garcia v. Director, OWCP*, 12 BLR 1-24 (BRB 1988). The district director rejected this Petition, issuing on April 13, 2000 a "Proposed Decision and Order Denying Request for Modification." DX-176. This claim was then referred to the OALJs, DX-183, and a formal hearing was conducted before the undersigned as noted above.

Duplicate Claim

Because Claimant seeks benefits more than one year after the denial of his first claim by the administrative law judge on September 1, 1988, DX-19, the 1990 filing constitutes a duplicate claim. 20 C.F.R. § 725.309(d) (2000). A duplicate claim must be denied on the basis of the prior denial unless a claimant demonstrates that there has been a material change in conditions. *Id*.

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[3] The Board observed in a footnote that Claimant's attorney had "stipulated [before Judge Kaplan] that there was no mistake of fact in Judge Teitler's Decision and Order." DX-108; *Hashin v. Reading Anthracite Co.*, BRB No. 95-0708 BLA, slip op. 2 n. 2 (Aug. 24, 1995)(unpub.).

[4] *See Robbins v. Cyprus Cumberland Coal Co.*, 146 F.3d 425, 21 BLR 2-495 (6th Cir. 1998); *Cunningham v. Island Creek Coal Co.*, 144 F.3d 388, 21 BLR 2-384 (6th Cir. 1998); *Pukas v. Schuylkill Contracting Co.*, 22 BLR 1-69 (2000).

In order to evaluate whether Claimant has demonstrated a material change in conditions, I will consider whether Claimant has established, by a preponderance of the new evidence that was developed subsequent to the denial of the prior claim on September 1, 1988, at least one of the elements of entitlement previously adjudicated against him. *Allen v. Mead Corp.*, 22 BLR 1-63 (2000) (*en banc*); *see Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 317, 20 BLR 2-76 (3d Cir. 1995); *Cline v. Westmoreland Coal Co.*, 21 BLR 1-69 (1997). If this threshold burden is met, Claimant is entitled to a full adjudication of his claim based on the record as a whole. *Id.*

Under the Director's "one-element standard," which has been adopted by the Third Circuit in *Swarrow*, a miner is afforded the opportunity to establish a material change in conditions by proving any element of entitlement *previously adjudicated against him*. *See Caudill v. Arch of Kentucky, Inc.*, 22 BLR 1-__, BRB No. 98-1502 BLA (Sept. 29, 2000)(*en banc*)(Sixth Circuit case). The Board has ruled that the focus of the material change standard is on specific findings made against the claimant in the prior claim; an element of entitlement which the prior administrative law judge did not explicitly address in the denial of the prior claim does not constitute "an element of entitlement previously adjudicated against a claimant." *Caudill*; *see Asher v. Director, OWCP*, BRB No. 00-0307 BLA, slip op. 3 (Dec. 15, 2000) (unpub.) (Sixth Circuit case); *Sargent v. Bullion Hollow Enterprises, Inc.*, BRB No. 99-0668 BLA, slip op. at 2-3 (Sept. 29, 2000) (unpub.) (applying *Caudill* in Fourth Circuit case).

Because the denial of the first claim was based on Claimant's failure to establish pneumoconiosis, DX-19, Claimant must now prove that element in order to demonstrate a material change in conditions.

Modification

This case presents the relatively uncommon procedural question presented by Claimant's request for modification of the duplicate claim. Section 22 of the Longshore and Harbor Workers' Compensation Act provides in part that

> upon his own initiative, or upon the application of any party ... on the ground of a change in conditions or because of a mistake in a determination of fact ... the [fact-finder] may, at any time ... prior to one year after the rejection of a claim, review a compensation case ...

33 U.S.C. § 922, as incorporated by 30 U.S.C. § 932(a) and implemented by 20 C.F.R. § 725.310 (2000). Section 22 provides the sole avenue for changing otherwise final decisions on a claim. *Metropolitan Stevedore Co. v. Rambo*, 515 U.S. 291, 295 (1995) (*Rambo I*); *Kinlaw v. Stevens Shipping and Terminal Co.*, 33 BRBS 68 (1999), *aff'd.*, 238 F.3d 414 (4th Cir. 2000) (Table).[5]

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[5] The modification procedure, and the adjudicator's authority to reopen the claim, is "easily invoked," *Betty B Coal Co. v. Director, OWCP*, 194 F.3d 491, 497, 22 BLR 2-1 (4th Cir. 1999)(*Stanley*), and the decision whether to grant modification on the basis of a mistake in determination of fact is committed

The Board has held that to determine whether a party has established a change in conditions pursuant to Section 725.310, an administrative law judge must perform an independent assessment of the newly submitted evidence, considered in conjunction with the previously submitted evidence, to determine whether the weight of the new evidence is sufficient to establish at least one element of entitlement which was not proven in the prior decision. *See Nataloni v. Director, OWCP*, 17 BLR 1-82 (1993); *Kovac v. BCNR Mining Corp.*, 14 BLR 1-156 (1990), *modified on recon.*, 16 BLR 1-71 (1992); *see also Kingery v. Hunt Branch Coal Co.*, 19 BLR 1-6 (1994). It must accordingly be determined whether Claimant has established a "basis for modification,"[6] and then "whether modification is warranted by considering all of the relevant evidence of record[7] to discern whether there was, in fact, a change in

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to the adjudicator's discretion. *See Kinlaw*, 238 F.3d 414, 2000 U.S.App. LEXIS 31354 at * 8-10 (4th Cir. 2000)(table), *aff'g* 33 BRBS 68 (1999); *see also Duran v. Interport Maintenance Co.*, 27 BRBS 8, 14 (1993) (Board reviews Section 22 findings under abuse of discretion standard). Any request for modification entails an inquiry into both whether a mistake in determination of fact was made or a change in conditions has occurred. *See National Mines Corp. v. Carroll*, 64 F.3d 135, 139, 19 BLR 2-329 (3d Cir. 1995). At the formal hearing, however, counsel specifically stated that Claimant was not alleging a mistake in determination of fact. TR-7; *see* fn. 3, *ante*.

[6] In an earlier decision in this case, the Board stated that the administrative law judge erred by failing to find whether Claimant had established a "basis for modification" prior to reaching the merits of entitlement, but that this error was harmless because the administrative law judge had evaluated the record as a whole. *See* DX-108 at 3. The Board has clarified this procedure in a recent Longshore case, stating that

> [w]here a party seeks modification based on a change in condition, an initial determination must be made as to whether the petitioning party has met the threshold requirement by offering evidence demonstrating that there has been a change in claimant's condition. *See Duran v. Interport Maintenance Corp.*, 27 BRBS 8 (1993). This initial inquiry does not involve a weighing of the relevant evidence of record, but rather is limited to a consideration of whether the newly submitted evidence is ... sufficient to bring the claim within the scope of Section 22. If so, then the administrative law judge must determine whether modification is warranted by considering all of the relevant evidence of record to discern whether there was, in fact, a change in claimant's physical ... condition from the time of the initial [decision] to the time modification is sought. Once the petitioner meets its initial burden of demonstrating a basis for modification, the standards for determining the extent of disability are the same as in the initial proceeding.

Jensen v. Weeks Marine Inc., 33 BRBS 147, BRB No. 00-0203 and 00-0203A, slip op. 4 (2000) (citations omitted).

[7] The "duplicate claim" record consists of the evidence developed subsequent to the final denial of the 1987 claim on September 1, 1988. DX-19. While this decision is based on a *de novo* review and

claimant's physical ... condition[.]" *See Jensen v. Weeks Marine, Inc.*, 34 BRBS 147, BRB Nos. 00-0203 & 0203A, slip op. 3-4 (2000). In every instance, the party who seeks to reopen a claim on modification bears the burden of proof. *Metropolitan Stevedore Co. v. Rambo,* 521 U.S. 121, 138-39 (1997) (*Rambo II*); *Greenwich Collieries v. Director, OWCP*, 990 F.2d 730, 736, 17 BLR 2-64 (3d Cir. 1993), *aff'd* 512 U.S. 267 (1994).

With this in mind, I turn to the merits of Claimant's Petition for Modification. Claimant would prevail in this instance by showing on modification that the prior determination, that he has failed to prove a material change in conditions, is mistaken, or that his condition has changed since the initial denial of the duplicate claim by showing that he now suffers from pneumoconiosis.

Medical Evidence

The record includes the following new evidence that has been submitted for evaluation of Claimant's current Petition for Modification:

X-rays

Exhibit No.	X-Ray Date	Reading Date	Physician/Credentials	Diagnosis/Comment
DX-167	08-21-99	08-23-99	Conrad BCR	1/1
CX-1	08-21-99	01-07-01	Malnar B/BCR[8]	1/0, pleural abnormalities consistent with pneumoconiosis
CX-3	08-21-99	12-18-00	H. K. Smith B/BCR[9]	1/0

consideration of this record, not all of the evidence that has been introduced prior to the instant request for modification, and has been set forth in prior decisions on the 1990 claim, will be listed except as required for an analysis of the current request for modification. *See generally Wheeler v. Apfel*, 224 F.3d 891, 895 n. 3 (8th Cir. 2000). Only if the duplicate claim is reopened pursuant to Section 22, and a material change under Section 725.309(d) is found with a finding that Claimant has established pneumoconiosis, then would the entire administrative record, dating from the 1987 claim, and all elements of entitlement, be considered *de novo.*

[8] Dr. Malnar's resume documents teaching experience at Columbia Hospital, St. Anthony's Medical Center, Chicago Osteopathic Hospital and Olympia Fields Osteopathic Hospital. CX-8.

[9] Dr. Smith has been a Clinical Assistant Professor at the Philadelphia, New York and New England Colleges of Osteopathic Medicine. CX-7.

EX-2	08-21-99	10-16-00	Laucks B/BCR	negative
EX-3	08-21-99	07-21-00	Wheeler B/BCR[10]	negative
DX-174	01-12[13]-00	01-12[13]-00	Levinson	0/0
CX-2	01-13-00	01-07-01	Malnar B/BCR	1/0, pleural abnormalities consistent with pneumoconiosis
CX-4	01-13-00	12-18-00	H. K. Smith B/BCR	1/0
DX-175	01-13-00	02-25-00	Wheeler B/BCR	negative
DX-180	01-13-00	04-04-00	Laucks B/BCR	0/0

Medical Opinions

Claimant introduced the January 15, 2001 medical report and February 22, 2001, deposition testimony of Dr. Soli F. Tavaria, M.D. CXs-6, 10. Dr. Tavaria has been Claimant's physician since 1982, and for the past few years has seen Mr. Hashin every two to three months. CX-6, 10 at 5.

He reported on January 15, 2001 that Claimant complained of breathing problems, including increasing shortness of breath on walking one to two blocks and that he had to stop numerous times while walking. Mr. Hashin also complained of a productive cough, two pillow orthopnea and shortness of breath on walking up one flight of stairs. Claimant also reported bouts of "PND" or "paroxysmal nocturnal dyspnea," a phenomenon which forced him to awaken at night because he could not breathe. CX-6; CX-10 at 6. Dr. Tavaria observed that Claimant had stopped smoking in 1955, and that he had worked for 35 years in coal mining, leaving the mines in 1983.

An chest examination revealed an increased PA diameter and "mild to moderate wheezing in all 6 lung fields." There was no peripheral edema. *Id*. Referencing the variety of Claimant's medications, his examination of Mr. Hashin, the results of a pulmonary function study, and a chest x-ray taken on August 23, 1999, Dr. Tavaria concluded that Claimant "is totally and completely disabled due to [coal workers'] pneumoconiosis." CX-6. Dr. Tavaria is board-certified in internal medicine. CXs-9, 10 at 4, 15. The doctor acknowledged that Claimant has suffered from "coronary artery disease with angina, history of hernia surgery, diabetes mellitus and old CVA." Mr. Hashin had undergone coronary bypass surgery and

[10] Dr. Wheeler has been an Associate Professor of Radiology at the Johns Hopkins University since 1974. Prior to that time he had been an Assistant Professor of Radiology from 1969, and an Instructor in Radiology from 1968 to 1969. DX-175.

his diabetes was being controlled. Claimant was taking a number of medications, including two inhalers. *Id*. at 6-8, 19.

Dr. Tavaria explained that findings of an increased chest diameter on physical examination, could be caused by an inability to exhale all of the air out of the lung, a condition that could be caused by scarring. CX-10 at 9. Results from ventilatory studies administered in 2000 and the prior year indicated a "severe restrictive lung disease and borderline response to bronchodilator therapy." *Id*. at 11. He strenuously disputed the contrary opinions of Dr. Levinson, who did not diagnose pneumoconiosis or find Claimant totally disabled, criticizing that expert's failure to account for Claimant's use of two inhalers. CX-10 at 19.

Dr. Tavaria also rejected the opinions of consultants who questioned the validity of pulmonary function testing conducted at his office, explaining that he would defer to the observations of the technician who oversaw Claimant's performance of the tests over the opinions of the consultants who merely reviewed the studies -- Drs. Kaplan and Levinson. CX-10 at 17. He did not personally observe the administration of the tests. *Id*. at 28.

On cross-examination, Dr. Tavaria admitted that complaints of shortness of breath and productive cough are not specific to any diagnosis, but stressed that there would not be "many other things that would cause you to cough and cough up gray material." Although smoking would not cause a person to cough up phlegm, he agreed that it could cause that type of symptom. *Id*. at 19-20. He recalled that Claimant had undergone four-vessel bypass surgery. He confirmed that, while coronary artery disease does not cause shortness of breath, myocardial infarction, which Claimant had, can cause this symptom. *Id*. at 21. He acknowledged that the physical examination findings revealed a normal respiratory rate, and that an expanded chest could be caused by smoking, as can wheezing. Dr. Tavaria based his diagnosis on his examination, x-rays, and Claimant's work history.

Confronted with evidence of negative x-ray rereadings, Dr. Tavaria nevertheless affirmed his reliance on positive readings of Dr. Conrad "as a physician who I trust[.]" *Id*. at 22. As support for his conclusions, he emphasized the presence of numerous positive readings on file, explained that Claimant worked 37 years in the mines, his skin has "numerous coal marks," and that he had abnormal pulmonary function studies. Dr. Tavaria acknowledged that pneumoconiosis is primarily an x-ray diagnosis. *Id*. at 20, 23. Claimant's smoking would be irrelevant, because he quit 46 years ago. *Id*. at 31. The testimony confirmed that his examination found no edema, clubbing or cyanosis. He opined that Claimant was not disabled by his cardiac problem; it was not a significant problem.

Dr. Tavaria explained on redirect examination that his ventilatory studies measured lung volumes and diffusion capacity, factors less dependent on a patient's effort in the performance of the test. Total lung capacity figures of 42 percent were abnormal. He offered that his diagnoses and assessment were based on medical, and not "legal or regulatory" standards. *Id*. at 34-35.

The doctor issued a report dated September 17, 1999 after seeing Claimant on September 13th. DX-162. Claimant complained of shortness of breath on walking one-half to one block on level ground,

climbing one flight of stairs, and told Dr. Tavaria his breathing had been getting worse. On physical examination, Dr. Tavaria detected "mild wheezing in all 6 lung zones and decreased expiratory air movement." He noted that a chest x-ray revealed 1/1, and a pulmonary function study indicated a "severe restrictive lung disease and a borderline response to bronchodilator therapy." Dr. Tavaria diagnosed "1. Coal worker's pneumoconiosis with shortness of breath[,] 2. Coronary artery disease with coronary artery bypass graft [and] 3. Diabetes mellitus[,]" explaining that

> this man has worked 30 to 35 years in the coal industry. He has shortness of breath on minimal exertion ... markedly abnormal pulmonary function study showing severe restrictive lung disease ... a chest x-ray showing pneumoconiosis ... [he is] totally and completely disabled from his pulmonary condition."

DX-162.

Claimant was examined on January 13, 2000 by Dr. Sander J. Levinson, M.D., who reported his findings and conclusions in a February 4, 2000 report and in deposition testimony. DX-174; EX-3. Dr. Levinson is board-certified in internal medicine with further certification in the sub-specialty of pulmonary diseases. He also has a teaching appointment as an Assistant Clinical Professor of internal medicine at the Temple University School of Medicine. EX-3 at 5.

Dr. Levinson elicited complaints of shortness of breath, dyspnea when walking one block on the level or climbing four to five steps. Claimant told of a productive cough, and some wheezing and chest pain. Dr. Levinson also administered clinical tests, including a ventilatory examination which was performed with poor effort, arterial blood gas study with normal results, and an electrocardiogram. He noted that Claimant was seeing Dr. Tavaria, and listed some of Mr. Hashin's medications, including a bronchodilator. Dr. Levinson neglected to note Claimant's use of inhalers, a shortcoming in the medical history that has been pointed out by Dr. Tavaria. DX-174. Dr. Levinson disagreed with Dr. Tavaria's diagnoses and disability assessments.

Dr. Levinson also testified at a January 12, 2001 deposition. EX-3. He reiterated findings made on the basis of the January 13, 2001 examination, and pointed out that he had also examined Mr. Hashin on two prior occasions: July 23, 1993 and April 19, 1995. *Id*. at 7-8. Dr. Levinson reiterated that he had recorded a detailed work history, and also recalled a smoking history of one to two years. In addition to the results of his physical examination, he considered x-ray interpretations, clinical tests and other medical records. On physical examination, Dr. Levinson found no evidence of cyanosis or edema, the lungs exhibited "clear breath sounds" and were "clear to percussion and auscultation." Dr. Levinson found no edema, cyanosis or clubbing. *Id*. At 12-15.

Claimant underwent a pulmonary function test, performing the trials with fair effort. Dr. Levinson noted that "even with a fair effort, the results were fairly decent." The results indicated to Dr. Levinson a "mild reduction[,]" without much change after the administration of a bronchodilator. A better effort on this

effort-dependent test, in Dr. Levinson's view, would have resulted in greater results. He continued that, under the Part 718 regulations, this would be an invalid study. *Id*. At 16-18. Dr. Levinson administered an arterial blood gas test, which produced normal results. He also reviewed the results of ventilatory studies conducted for Dr. Tavaria on July 1, 1999 and July 6, 2000, and opined that their tracings indicated invalid tests. EX-3 at 20.

Based on his review of pertinent medical history and records, physical examinations and clinical testing, Dr. Levinson concluded that Claimant does not suffer from coal workers' pneumoconiosis or any dust-related respiratory condition. *Id*. at 23-24. He explained that there was no evidence, other than x-rays, to support a diagnosis of pneumoconiosis in this case. *Id*. He further testified that Claimant suffers from "significant arteriosclerotic heart disease[,]" and shows "evidence of coronary artery disease with a prior inferior wall myocardial infarction." *Id*. at 25. Claimant also is afflicted with significant diabetes mellitus under treatment [and] significant cerebral vascular disease and ... a stroke[.]" *Id*. None of these conditions is related to Claimant's coal mine work.

On cross-examination, Dr. Levinson acknowledged that complaints of shortness of breath, productive cough and wheezing may be associated with coal workers' pneumoconiosis, although they are nonspecific. He confirmed that a history of 35 years of work in the strip mines is a significant exposure history. *Id*. at 31-32. Dr. Levinson agreed with Dr. Tavaria that Claimant's smoking did not contribute to his breathing problems. The results of the ventilatory study administered by him were abnormal; arterial blood gas study results were normal for a person Claimant's age.

The following clinical test results have been introduced into the record in conjunction with Claimant's most recent Petition for Modification.

Pulmonary Function Studies

Ex. No.	**Date**	**Age**	**HT.**	**FEV_1**	**FVC**	**MVV**	**FEV_1/FVC**	**Qualify**[11]

[11] "Qualifying values" for the FEV1, FVC and the MVV tests are measured results less than or equal to the values listed in the appropriate tables of Appendix B to 20 C.F.R. Part 718. *See Director, OWCP v. Siwiec*, 894 F.2d 635, 637 n. 5, 13 BLR 2-259 (3d Cir. 1990). Assessment of the pulmonary function study results is dependent on the Claimant's height. I find that Claimant's height is 65.5 inches for purposes of evaluating the pulmonary function studies. *See Protopappas v. Director, OWCP*, 6 BLR 1-221 (1983); *see generally Meyer v. Zeigler Coal Co.*, 894 F.2d 902, 13 BLR 2-285 (7th Cir.), *cert. denied* 498 U.S. 827 (1990). This figure is calculated on the basis of measurements from numerous ventilatory test protocols of record. Moreover, the pulmonary function tables presented at Appendix B, 20 C.F.R. Part 718, show values for miners up to 71 years of age. For testing administered to Claimant in 1999 and 2000, when he was 72 and 73 years old, I will reference the values listed for a miner of 71 years of age and extrapolate from that point. For example, the qualifying FEV1 value for a 71-year old miner 65.5" tall

DX-167	07-01-99	72	66"	1.46	2.45	38.77	60%	Yes
	(post bronchodilator)			1.55	2.00	32.54	77%	No

Dr. Tavaria found "good" cooperation and comprehension in the performance of this study.

This test was invalidated by Drs. Robin L. Kaplan, Sander J. Levinson and R. Sahillioglu. DXs-172, 173, 168. Dr. Kaplan pronounced the test "not valid due to suboptimal and inconsistent effort[.]" He explained that the forced expiratory tracings indicated "erratic and highly variable forced expiratory efforts ... the duration of each ... is insufficient, as the longest effort recorded is four seconds, substantially less than the six second minimum specified in Part 718[.]"[12] The MVV results also convinced Dr. Kaplan of suboptimal effort, as shown by Dr. Kaplan's computations. DX-172. Dr. Kaplan is board-certified in internal medicine, pulmonary medicine and critical care medicine. EX-4.

Dr. Levinson said this "is clearly an invalid pulmonary function study [because of unacceptable effort] since each and every one of the forced vital capacity curves indicate an unsatisfactory start of exhalation characterized by excessive hesitation[.]" Slowing of exhalation was evidence to Dr. Levinson that Claimant did not exert "maximal effort throughout the forced vital capacity attempt." He also detected interruption in performance, and MVV tracings which suggested a variable and inconsistent effort. DX-173.

Dr. Sahillioglu found the test unacceptable because of "less than optimal effort, cooperation and comprehension" and cited improper performance, "breath holding, hesitancy flow volume loop - and inconsistency. Poor effort MVV restrictive defect need be verified by TLC determination." DX-168. He is board-eligible in internal medicine and pulmonary diseases. DX-169.

In rebuttal to criticism of this study, Dr. Tavaria emphasized that the test was performed using standard testing procedures, and that the attending technician had pronounced Claimant's performance as good, a factor more important to Dr. Tavaria than reviewers who merely examined the studies and performed calculations. CX-10 at 17.

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is 1.52. Based on the variation of the FEV1 curves over changes in age, I find that the qualifying values for Claimant at ages 72 and 73 are 1.51 and 1.50.

Pulmonary function and arterial blood gas studies are not themselves primarily utilized for the diagnosis of pneumoconiosis, but they constitute relevant evidence whose value as documentation is cited in the regulations. *See* 20 C.F.R. § 718.202(a)(4)(2000).

[12] The regulations in effect at the time this test was administered provided that the "effort [for the FEV1 and FVC trials] shall be judged unacceptable when the patient: ... (C) has not continued the expiration for [at] least 5 sec. or until an obvious plateau in the volume-time curve has occurred[.]" 20 C.F.R. Part 718, Appendix B (2)(ii)(C) (2000).

Ex. No.	Date	Age	HT.	FEV_1	FVC	MVV	FEV_1/FVC	Qualify
DX-174	01-13-00	73	65"	2.07	2.66	37	78%	No
	(post bronchodilator)			2.08	2.82	47	74%	No

Dr. Levinson said that this test was performed with "fair" effort.

Ex. No.	Date	Age	HT.	FEV_1	FVC	MVV	FEV_1/FVC	Qualify
CX-5	07-06-00	73	66"	1.80	1.89	33.6	95%	No
	(post bronchodilator)			1.94	2.12	23.82	92%	No

A computer readout noted Claimant's cooperation and effort during testing as "good."

Dr. Kaplan reviewed this study, and in a January 13, 2001 report explained that it was invalid because the protocol did not comply with the Part 718 requirements. EX-4. First, he cited a "duration of effort [that] was less than the five-second minimum required by Part 718[.]" He found as additional evidence of Claimant's "inconsistent and sub maximal effort" the fact that the "actual MVV ... is less than half the expected value [based on the actual FEV1], indicating sub maximal effort[.]"

Dr. Tavaria defended the performance of this study. He reiterated that the protocol had been completed pursuant to standard testing procedures, and that his technician had observed first-hand good performance. He was critical of the consultants' opinions for the reasons expressed in defense of his earlier study, and further maintained that "if you compare the two studies [administered on July 1, 1999 with that performed July 6, 2000] they are almost identical and nobody could produce insufficient cooperation to equal degree one year apart." CX-10 at 18.

Arterial Blood Gas Studies

Ex. No.	Date	Physician	Alt.	pCO2	pO2	Qualify
DX-174	01-13-2000	Levinson		39.9	73.5	No

Discussion: Change in Conditions

At the outset, I find that Claimant has met the "threshold requirement by [pr]offering evidence ... [which is] sufficient to bring the claim within the scope of Section 22." *Jensen*; *cf*. *Amax Coal Co. v. Franklin*, 957 F.2d 355, 356, 16 BLR 2-50 (7th Cir. 1992) (proffered letter report insufficient to show deterioration in miner's condition). Nevertheless, upon review of this and the previously submitted evidence, evaluated in the context of the duplicate claim record as a whole, *Nataloni*; *see Kingery*; *see also Betty B Coal Co. v. Director, OWCP*, 194 F.3d 491, 500 n. 4, 22 BLR 2-1 (4th Cir. 1999)(*Stanley*)("change in conditions will always support de novo reconsideration"), I find that Claimant has not established on modification that he has pneumoconiosis. Because the weight of the new evidence

does not establish that he suffers from pneumoconiosis, Claimant has not established a material change in conditions.

Discussion: Medical Evidence

Section 718.202(a) sets forth four distinct methods relevant to demonstrating the existence of pneumoconiosis. In order to determine whether Claimant has established the presence of the disease, however, I must weigh all relevant evidence together to find whether Claimant has proven the existence of pneumoconiosis at 20 C.F.R. § 718.202(a) (2000). *See Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 25, 21 BLR 2-104 (3d Cir. 1997); *accord Island Creek Coal Co. v. Compton*, 211 F.3d 203, 208-09, 211 (4th Cir. 2000).

Claimant may initially demonstrate the existence of pneumoconiosis on the basis of x-rays which are interpreted as positive for the disease under the classification standards set forth at 20 C.F.R. § 718.102(b) (2000) as category 1, 2, 3, A, B, or C, according to the ILO-U/C classification system. *See Cranor v. Peabody Coal Co.*, 22 BLR 1-1 (1999)(*en banc* on recon.). A chest x-ray classified as category 0, including subcategories 0/1, 0/0, or 0/-, does not constitute evidence of pneumoconiosis. In reviewing the x-ray interpretations of record, I must consider the qualifications of the medical experts.[13] *Id*.

At the outset, I find that the x-rays taken on August 21, 1999 and January 13, 2000, are negative for pneumoconiosis. In both instances, I will credit the rereadings of these films by Dr. Wheeler on the basis of his credentials. DX-175; EX-3. Although these films have been interpreted for both sides by physicians who are dually qualified as B-readers and Board-certified radiologists, and Drs. Smith and Malnar have teaching experience, I find that Dr. Wheeler possesses the most impressive credentials, given his long-term academic experience as an Associate Professor in Radiology at Johns Hopkins. *See*

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[13] The following are used to designate a physician's radiological credentials: "B," which denotes that the physician is a qualified "B-reader" of x-rays. "BCR" means that the physician is board-certified in radiology. A B-reader who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by, or on behalf of, the Appalachian Laboratory for Occupational Safety and Health. 20 C.F.R. § 718.202(a)(1)(ii)(E) (2000); 42 C.F.R. § 37.51 (2000); *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308, 310 n. 3, 20 BLR 2-76 (3d Cir. 1995). A "Board-certified" physician has received certification in radiology by the American Board of Radiology, or the American Osteopathic Association. 20 C.F.R. § 718.202(a)(1)(ii)(C) (2000); *see Staton v. Norfolk & Western Railway Co.*, 65 F.3d 55, 57, 19 BLR 2-271 (6th Cir. 1995). It is permissible to accord greater weight to opinions of physicians who hold both credentials. *Cranor v. Peabody Coal Co.*, 22 BLR 1-1 (1999) (*en banc* on Recon.); *Roberts v. Bethlehem Mines Corp.*, 8 BLR 1-211 (1985). I may also give appropriate weight to the academic teaching credentials. *See Worhach v. Director, OWCP*, 17 BLR 1-105 (1993).

Worhach v. Director, OWCP, 17 BLR 1-105 (1993). At the most, I would find the newly submitted x-ray evidence to be "equally probative," and not sufficient to demonstrate pneumoconiosis. *See Cole v. East Kentucky Collieries*, 20 BLR 1-50 (1996).

Similarly, I find that the x-ray evidence in the duplicate claim record as a whole does not, on balance, demonstrate the presence of pneumoconiosis. First, either a slight majority, or an equal number, of interpretations of each of the chest x-rays developed for the duplicate claim are negative.[14] I find that no single film constitutes a positive x-ray. Although a bare appeal to numerical superiority is not appropriate, *see Sahara Coal Co. v. Fitts*, 39 F.3d 781, 782, 18 BLR 2-384 (7th Cir. 1994), "the balance of opinion is entitled to some though not controlling weight." *Id*. There are additional factors as well, for I also note that x-rays taken on February 26, 1991, January 22, 1992, November 13, 1992, July 29, 1993, April 19, 1996, include negative rereadings by Dr. Wheeler, whose qualifications are outlined above, and by either Dr. Scott or Dr. Gaylor, who possess similar credentials. *See* DXs-22, 23, 54, 56, 58, 86, 87, 88, 93, 94, 95, and 130. Again, the Board has held that an administrative law judge may rely on a medical expert's teaching experience in order to assign that expert's opinion greater probative weight. *Worhach*. In addition, their rereadings of these films are bolstered in every instance by negative readings by dually qualified radiologists.

I am mindful that Dr. Marshall was an Associate Professor of Radiology at the University of Louiseville from 1964 to 1967, an Assistant Professor from 1962 to 1964, and an Instructor from 1961 and 1962. DX-127. Dr. Mathur was an Instructor in Radiology at the University of Pittsburgh in 1971-1972, just after completing his residency. DX-127. As noted above, Drs. Smith and Malnar also have held academic positions. Nevertheless, Dr. Gaylor has been an Associate Professor of Radiology at Johns Hopkins since 1973, was an Assistant Professor at that institution from 1970 to 1973, and completed his postgraduate training there as an instructor for one year. DX-130 [EX-1]. Dr. Scott holds similar credentials, having been an Associate Professor at Johns Hopkins since 1986, and an Assistant Professor for two years prior to that. *Id*. Dr. Wheeler's credentials are as extensive as those of Dr. Scott. *See id*., DX-175; fn. 12, *ante*. Dr. Lautin has been an Assistant Clinical Professor at the Mt. Sinai Medical School

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[14] In addition to the newly submitted x-rays outlined in the text, the duplicate claim record includes readings of the following films: April 19, 1996 x-ray: DX-127 (six positive readings), DXs-113, 120, 130 (eight negative readings); October 11, 1995 x-ray: DX-109 (one positive reading), DXs-115, 116, 130 (five negative readings); July 29, 1993 x-ray: DXs-66, 67, 68, 81 (four positive readings), DX-90 (positive reading for pleural abnormalities which Dr. Soble said could show asbestosis; negative for parenchymal abnormalities), DXs-89, 91-95 (six negative readings); November 13, 1992 x-ray: DXs-50, 69-71, 81 (five positive readings), DXs-54, 56, 82-84 (six negative readings); January 22, 1992 x-ray: DXs-37, 65, 72 (three positive readings), DXs-42, 43, 51, 86-88 (eight negative readings); February 26, 1991: DXs-49, 76-79 (five positive readings), DXs-22-24, 53, 58, 85 (eight negative readings); November 30, 1990: DX-31 (negative reading); May 7, 1990 x-ray: DX-10 (positive), DXs-9, 29, 34 (three negative readings); November 24, 1989: DXs-29, 34 (two negative readings).

in New York. DX-130. Dr. Sundheim has been an Clinical Assistant Professor at Temple University School of Medicine. DX-34. In addition to the dual qualifications of most of employer's experts, the extensive teaching experience of these radiologists adds considerable weight to employer's case that the x-ray evidence as a whole does not demonstrate the presence of pneumoconiosis.[15]

Finally, even if the x-ray interpretations were considered equally probative, this "equipoise" would work against Claimant because he has the burden of persuasion by a preponderance of the x-ray evidence. *See Cole v. East Kentucky Collieries*, 20 BLR 1-50 (1996). The x-ray evidence in the duplicate claim does not demonstrate that it is more likely than not that Claimant suffers from pneumoconiosis.

Claimant cannot demonstrate pneumoconiosis at Section 718.202(a)(2), because the record contains no evidence which satisfies his burden of proof at this provision. Claimant is likewise precluded from employing the presumptions accorded under Section 718.202(a)(3), because there is no evidence of complicated pneumoconiosis, and Sections 718.305 and 718.306 are foreclosed because this claim was filed after January 1, 1982. 20 C.F.R. §§ 718.202(a)(2), (3), 718.305, 718.306 (2000).

A claimant can demonstrate the existence of pneumoconiosis on the basis of medical opinion evidence. 20 C.F.R. § 718.202(a)(4) (2000). A determination of the existence of pneumoconiosis may be made, notwithstanding a negative x-ray, if a physician, exercising sound medical judgment finds that the miner suffers from pneumoconiosis as defined in 20 C.F.R. § 718.201 (2000). Any such finding shall be based on objective medical evidence, such as arterial blood gas tests, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

Reviewing the duplicate claim record as a whole, I find that the weight of the newly submitted medical opinion evidence, evaluated in conjunction with the previously submitted medical opinions, does not demonstrate that Claimant now suffers from pneumoconiosis. Of the newly submitted opinions, the conclusions of Dr. Levinson are more persuasive that those of Dr. Tavaria. I am mindful that Dr. Tavaria has been Claimant's treating physician for many years; seeing Claimant every two months. His conclusions will be weighed in accordance with local circuit court precedent. *See Mancia v. Director, OWCP*, 130 F.3d 579, 21 BLR 2-114 (3d Cir. 1997). Nevertheless, Dr. Levinson's reports are more thoroughly supported by his findings and by the clinical testing of record,[16] and his credentials -- board-certification

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[15] This is not to say that teaching experience in radiology will compel deference to that radiologist's opinions in every case. This is but one factor to consider when weighing the x-ray interpretations. But Drs. Scott and Wheeler each have over 25 years in teaching; Dr. Gaylor 15. I am also mindful of the extensive clinical experience of Claimant's experts, and their practice in the field is impressive and has been taken into account.

[16] The arterial blood gas study administered by Dr. Levinson was considered to be normal. DX-174. His physical examination of Claimant detected no cyanosis and Claimant's lungs were "clear."

in internal medicine with a sub-specialty in pulmonary medicine -- provide him an additional edge -- Dr. Tavaria is board-certified in internal medicine. *See Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 441, 21 BLR 2-269 (4th Cir. 1997); *see also Lucostic v. United States Steel Corp.*, 8 BLR 1-46 (1985). I am mindful of Dr. Tavaria's criticism of Dr. Levinson's failure to note that Claimant has been using two inhalers, and have accounted for this factor in weighing the medical opinions.

In addition to work history and his findings on physical examination, Dr. Tavaria cites positive x-ray interpretations, including the readings by Dr. Conrad, as one of the bases for a diagnosis of pneumoconiosis. CX-10 at 16; *see id*. at 23 (agreeing that pneumoconiosis is primarily an x-ray diagnosis). While a medical opinion diagnosis of pneumoconiosis may be sufficient notwithstanding a negative x-ray, *see Taylor v. Director, OWCP*, 9 BLR 1-22 (1996), where x-ray evidence constitutes a part of the physician's documentation, his opinion may merit diminished probative weight if that film has been reread as negative and the x-ray evidence as a whole has been found insufficient to demonstrate the presence of the disease. *See Worhach*; *see generally Director, OWCP v. Rowe*, 710 F.2d 251, 255 n. 6, 5 BLR 2-99 (6th Cir. 1983).

Further, I credit the invalidation of clinical tests administered by Dr. Tavaria that are rendered by Dr. Levinson, and to a lesser extent Dr. Kaplan, again on the basis of their credentials. In addition to board-certification in internal medicine, a qualification they share with Dr. Tavaria, Drs. Kaplan and Levinson also hold certification in the subspecialty of pulmonary medicine. Their reviews are corroborated by that of Dr. Sahillioglu.

Granted, the opinion of a physician who administered a ventilatory study may be accorded deference. *See Consolidation Coal Co. v. Worrell*, 27 F.3d 227, 231, 18 BLR 2-290 (6th Cir. 1994). Nevertheless, the Secretary's regulations allow for the examination of pulmonary function testing by experts who can review the ventilatory tracings and determine the validity of a particular test. 20 C.F.R. § 718.103 (2000) & Part 718, Appendix B; *See Director, OWCP v. Siwiec*, 894 F.2d 635, 13 BLR 2-259 (3d Cir. 1990); *see generally Ziegler Coal Co. v. Sieberg*, 839 F.2d 1280, 1283, 11 BLR 2-80 (7th Cir. 1988). Thus, in assessing the probative value of a clinical study, a fact-finder must address "valid contentions" raised by consultants who review such tests. *See Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276, 18 BLR 2-42 (7th Cir. 1993); *Dotson v. Peabody Coal Co.*, 846 F.2d 1134, 1137-38 (7th Cir. 1988); *Strako v. Ziegler Coal Co.*, 3 BLR 1-136 (1981); *accord Winchester v. Director, OWCP*, 9 BLR 1-177(1986). The reviews of these tests further undermine the probative weight of Dr. Tavaria's conclusions.[17]

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[17] I do not accord full credit to Dr. Kaplan's reviews, to the extent that his criticism may not conform to the requirements of Appendix B to Part 718. He discounted the results of the July 1, 1999 and July 6, 2000 ventilatory tests in part because the duration of Claimant's forced expiratory effort fell below what Dr. Kaplan thought was the minimum allowed by the regulations. *See* EX-4. It is not clear whether Dr. Kaplan applied Appendix B, Section (2)(ii)(C) to gauge the effectiveness of this test. That provision does

Evaluating the medical opinions in the duplicate claim record as a whole, I find that the earlier conclusions of Drs. Kaplan and Levinson, that Claimant does not suffer from coal workers' pneumoconiosis or anthracosilicosis,[18] support Dr. Levinson's recent opinion and outweigh the conflicting opinions from Drs. Tavaria, Kraynak, Cubler and Kruk.[19] I have reached this conclusion upon reviewing all of the medical opinion evidence in the duplicate claim record, judging the "qualifications of the respective physicians, the explanation of their medical opinions, the documentation underlying their medical judgments, and the sophistication and bases of their diagnoses[,]" *see Akers*, 131 F.3d at 441, 21 BLR 2-269.

Specifically, I will accord weight to the opinions of Drs. Kaplan and Levinson on the basis of their credentials. Moreover, they each have examined Claimant on a number of occasions, and their medical reports, taken as a whole, have been logically consistent over the years. These experts have duly noted complaints of shortness of breath, dyspnea and a productive cough, but have persuasively explained that these phenomena do not compel a diagnosis of pneumoconiosis.

Further, their associated clinical test results, and a battery of negative x-ray readings, support their conclusions. Moreover, their findings on physical examinations have demonstrated clear lungs and have not indicated the presence of indicia of lung disease such as cyanosis or edema. Indeed, their physical examination findings are to some extent consistent with similar observations by Drs. Cubler (DX-7: thorax

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not require a duration of six seconds, as Dr. Kaplan would have required for the 1999 study, and it is not clear whether Dr. Kaplan attempted to ascertain whether there an "obvious plateau in the volume-time curve ha[d] occurred[.]" 20 C.F.R. Part 718, Appendix B (2)(ii)(C). But I will credit Dr. Kaplan's observation of "erratic and highly variable forced expiratory efforts[.]" EX-4. Nor will I credit Dr. Kaplan's invalidations of Dr. Kraynak's pulmonary function studies administered on October 11 and November 3, 1995. DX-112. Similarly, Dr. Levinson's review of the October 11, 1995 test will likewise be accorded no weight. DX-112. Dr. Kaplan, in his June 26, 1997 review of an April 28, 1997 test, again cited a "six second" duration requirement that is not in the regulations in effect at the time of the test. But he provides valid alternative reasons for discounting the test's reliability. DX-130 [EX-8].

[18] *See* DX-26 (Kaplan deposition, March 22, 1991, medical report, October 19, 1990); DX-28 (Kaplan medical record review); DX-48 (Kaplan medical record, November 23, 1992); DX-89 (Levinson medical report, September 1, 1993); DX-98 (Levinson deposition, March 18, 1994); DX-113 (Levinson medical report, May 7, 1996); DX-130 (Levinson deposition, May 19, 1997).

[19] Dr. Cubler examined Claimant on May 7, 1990, and diagnosed pneumoconiosis "by chest x-ray[,]" and found a minimal obstructive lung disease by breathing test. DXs-6, 7. Dr. Raymond J. Kraynak, who has also treated Claimant for years diagnosed pneumoconiosis and assessed Claimant as totally disabled. DX-21 (deposition, April 18, 1991); DX-63 (deposition, March 25, 1994); DX-114 (letter report, June 5, 1996); DX-129 (deposition, July 11, 1997). Dr. Stephen M. Kruk, who is board-certified in internal medicine, examined Claimant on October 15, 1992, and found Claimant to be totally disabled due to pneumoconiosis. DX-41.

and lungs normal to inspection, resonant to percussion, no wheezes or rales, although he did find "increased breath sounds" and that Claimant's chest was "expanded"); Kruk (DX-41: no cyanosis, no clubbing, no peripheral edema and lungs "clear")and Tavaria (DX-30: increased PA diameter and bilaterally poor air entry, but no wheezing, rales or rhonchi). I note further that Dr. Kraynak, who has consistently found indications of cyanosis, acknowledged in deposition testimony that cyanosis may or may not be due to low oxygen levels, DX-21 at 14, and that complaints and findings of shortness of breath and slightly cyanotic lips "are not solely attributable to an individual suffering from coalworkers' pneumoconiosis." DX-63 at 19.

Moreover, the clinical testing support for the opinions of Drs. Tavaria and Kraynak has been undermined by the invalidation reports from a variety of employer's experts.[20] This further detracts from the probative weight of these experts. *See Siwiec*.

Finally, while a diagnosis of pneumoconiosis may be rendered "notwithstanding a negative x-ray," the opinions of Claimant's experts are significantly based on positive readings. Dr. Tavaria agreed that pneumoconiosis is essentially a diagnosis by x-ray. CX-10. Dr. Cubler cites x-ray results in making his diagnosis. DX-7. Drs. Kraynak and Kruk also cite positive x-ray reports in forming their diagnoses of pneumoconiosis. Given this partial reliance on x-ray readings, I find the opinions of Claimant's to be somewhat less persuasive as a result. *See generally Rowe*; *Worhach*.

The final task is to determine whether Claimant has established the existence of pneumoconiosis, weighing all relevant evidence together. *See Williams.* In view of findings that neither the x-ray nor medical opinion evidence demonstrate the presence of pneumoconiosis, I conclude that this evidence, taken in concert, does not establish that Claimant has acquired the disease. Again, I will credit the medical opinions of Dr. Levinson as the most thorough, documented, and reasoned. *Akers*; *Lucostic*. These reports are supported to a lesser extent by the opinions from Dr. Kaplan.[21]

In view of my findings that Claimant has not established that he now suffers from pneumoconiosis, he is not entitled to modification of the duplicate claim, and has as a result failed to establish a material

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[20] The validity of the pulmonary function testing has been a point of dispute throughout the course of this claim. *See* n. 17, *ante*. In the final analysis, I will credit the reviews by Dr. Levinson (except DX-112), who has invalidated a number of qualifying pulmonary function studies.

[21] I will withhold unconditional credit from Dr. Kaplan's opinions. He explains that signs of an increased chest diameter, and a pulmonary restriction, can be explained by extrinsic factors, *viz*. structural factors derived from the effects of Claimant's bypass surgery in 1990. *See* DXs-26 at 12, 28, 48. But Drs. Cubler and Tavaria observed this phenomenon prior to Claimant's coronary bypass operation. *See* DXs-7, 30. I duly note this fact, and have accounted for it in assessing the probative weight of Dr. Kaplan's conclusions.

change in conditions.[22] *See LaBelle Processing Co. v. Swarrow*, 72 F.3d 308, 20 BLR 2-76 (3d Cir. 1995); *Caudill*; *Cline*.

CONCLUSION

Because Claimant has failed to prove a material change in conditions by not proving pneumoconiosis, I must conclude that he has failed to establish entitlement to benefits under the Act.

ORDER

The claim of CHARLES HASHIN for benefits under the Act is hereby DENIED.

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Ainsworth H. Brown
Administrative Law Judge

Attorney Fees

The award of an attorney's fee under the Act is permitted only in cases in which Claimant is found to be entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to Claimant for services rendered to him in pursuit of this claim.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481 (2000), any party dissatisfied with this decision and order may appeal it to the Benefits Review Board within 30 days from the date of this decision and order, by filing a notice of appeal with the Benefits Review Board at P.O. Box 37601,

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[22] I also find, in passing, that the duplicate claim record does not establish total respiratory disability. I will fully credit the opinions of employer's experts, Drs. Kaplan and Levinson, on this issue. Moreover, the record contains an overwhelming amount of non-qualifying clinical study that has not been invalidated. Even accounting for Claimant's complaints and sincere testimony regarding his breathing problems, the well-reasoned and fully documented opinions of Drs. Kaplan and Levinson, as well as the non-qualifying arterial blood gas and pulmonary function tests, constitute contrary probative evidence which undermines the case for total respiratory disability.

Washington, DC 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, DC 20210.